Member Consent for Financial Responsibility for Unreffered/Non-covered Services

Member Information

Member Name ______________________________

Member's ID # ______________________________

Provider Information

Provider Name ______________________________

Provider's ID # ______________________________

Specialty or Department ______________________________

Type of Service ______________________________

Member must complete this section

As a member of: (Circle one)

Keystone Health Plan East (HMO)	Personal Choice® (PPO)
Keystone 65 (HMO)	Personal Choice 65℠ (PPO)

I understand that... (Check the appropriate box):

- ❑ A referral from my Primary Care Physician is required for any and all non-Emergency outpatient hospital/ specialist services. I acknowledge that I do not have a referral with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral, I will be held responsible for any payments incurred for these services. (HMO)
- ❑ I understand that this is a noncovered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services. I understand that I have the right to appeal this determination. (ANY)
- ❑ I understand that certain services will only be covered by my insurance carrier when performed by designated providers or in certain settings (e.g., capitated radiology or lab services, and DME services). I understand and agree that I will be financially responsible for certain services that I choose to receive from the provider noted above rather than the appropriate network provider or in the appropriate setting. The provider has specifically explained to me the services for which I will be financially responsible. (ANY)
- ❑ I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment. (ANY)

______________________________ ______________________________

Member's signature *Employer name (if applicable)*

______________________________ ______________________________

Date *Employer address (if applicable)*

______________________________ ______________________________

Witness / office staff *City* *State* *ZIP*

Independence Blue Cross offers products directly through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

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